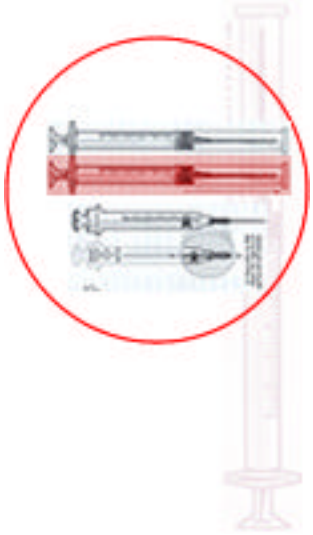
NIOSH recommends that health care facilities use safer medical devices to protect workers from needlestick and other sharps injuries. Since the passage of the Needlestick Safety and Prevention Act in 2000 and the subsequent revision of the OSHA Bloodborne Pathogen Standard, all health care facilities are required to use safer medical devices.

SAFER MEDICAL DEVICE IMPLEMENTATION IN HEALTH CARE FACILITIES

SHARING LESSONS LEARNED

NIOSH has asked a small number of health care facilities to share their experiences on how they implemented safer medical devices in their settings. These facilities have agreed to describe how each step was accomplished, and also to discuss the barriers they encountered and how they were resolved, and most importantly, lessons learned.



Phase 1 Report - Form a Sharps Injury Prevention Team

Facility Background

Daily census for this small home health agency averages 25 patients, primarily geriatric. This agency is Medicare and Medicaid certified. Our Medicare license is for one county. We have a multi-cultural work force, consisting of 11 employees, including one fulltime RN case manager, one RN on call, one physical therapist, two occupational therapists, two home health aides, and other support staff. We subcontract for a Speech Language Pathologist as needed. A medical social worker and a dietician are shared with our parent company, which is a skilled nursing facility. Our parent company also provides supply management and other administrative support. (We are located on the administrative floor of this skilled nursing facility.)

Forming the Sharps Injury Prevention Team

In response to the NIOSH safer medical devices alert, we formed a sharps injury prevention team separate from our parent company in order to have a focus on the unique working environment and conditions of home health. Two core people formed the Sharps Injury Prevention Team: the RN Executive Director and the RN Case Manager. The RN Executive Director represented administration and assumed the role of team coordinator, including the utilization of agency financial resource. The case manager represented front-line clinical staff. Including a front-line staff person was important because clinical staff use the equipment regularly and have definite opinions on equipment safety, ease of use, and reliability. The clinical staff will also be critical to the following phases: Identify Priorities, Identify and Screen Safer Medical Devices, Evaluate Safer Medical Devices, Implement, and Monitor the Use of the New Safer Medical Device. Their involvement in every step of the process for this committee will ensure its success. We did not include the on-call RN because of her limited work schedule (predominately weekends).

We encountered no negativism toward the formation of the committee. Rather, people in our organization recognized that it was important, and that it provided an avenue of communication and process regarding safer medical equipment. There was also enthusiasm and awareness for improved equipment.

Meetings were held once a month in conjunction with our team meetings day so that the RN Case Manager did not have to make an additional trip in to our office. The meetings were never longer than 30 minutes.

Lessons Learned and Recommendations

Our original sharps injury prevention team proved to be too small since the effects of the team were also felt in the parent company. The parent company eventually became

involved in the purchasing of equipment and approached to develop policies and procedures. Given this development, we debated two options for reconstituting our team.

- One option was for the sharps injury prevention team to have a flexible membership to include individuals from the parent company, as their services are needed. This would contain all communication within the sharps injury prevention team. In various stages the team will need to work with the parent company in purchasing and education support.

- A second option was to have a representative from the home health sharps prevention team sit on the parent company's team. This would balance the need to maintain home health perspective as well as providing access to the parent company. Home health initiatives could be brought to the parent company's team for support when needed as well as have input in the parent company initiatives that could affect them. This would also secure the link to purchasing and education in the parent company.

We decided on the first option: to have a "flexible" membership that includes parent company representatives as needed. The reason we chose this option over the second one was that the parent company's team does not meet on a regular basis. If the parent company team does establish a regular meeting schedule, we will have a member of our team represented. But in the meantime, accessing a parent company representative as needed will suit our purposes.

Not anticipated on our team was staff turnover. The full time RN case manager left and was replaced by an RN new to the home health field. The new RN required a review on current agency policies and procedures, OSHA, and goals for the team.

Costs

The RN Executive Director spent approximately 3 hours forming the Sharps Injury Prevention Team. This includes meetings with the RN Case Manager. The case manager received a review on current agency policies and procedures, OSHA, goals for the team. Three meetings were with individuals located in the skilled nursing residence and who would be effected / contacted by the team in the future. This included the Director of Nursing Services, the Administrator, the Manager of supplies / purchasing. Approval was received as well as opening communication channels for future projects. There were no costs associated with overtime, or non-labor items.

Table: Sharps Injury Prevention Team formation and time

Type of Staff	Hours spent
Administrative / management	3
Clinical	1